



NASA Mishap Report

Part A: Mishap Details

MASTER FILE NO.

NOTE: FILL IN ALL KNOWN UNSHADED BLOCKS WITHIN 24 HOURS.

DETAILS

1. DATE OF INCIDENT 3/20/2008	2. TIME OF INCIDENT	3. GENERAL LOCATION (Building, Area, Facility, etc.)	4. EXACT LOCATION (street, floor, room, etc.)		
5. RESPONSIBLE ORGANIZATION	6. CONTRACT NUMBER	7. ORG. FILE NUMBER	8. ORGANIZATION POINT OF CONTACT	9. MAIL CODE	10. PHONE
11. MISSION AFFECTED, IF KNOWN		12. PROGRAM IMPACT, IF KNOWN (Describe impact in terms of delay, cost adjustment, etc.)			
13. INCIDENT DESCRIPTION (Do not use actual names, include in the description the sequence of events, extent of injury or property damage, cause, etc., if known.)					

IMPACT SUMMARY

14. CHECK ALL OUTCOMES FROM THIS EVENT THAT ARE KNOWN FACTS (Do not check any box that indicates any future potential or outcome.)

<input type="checkbox"/> FATALITY <input type="checkbox"/> PERMANENT DISABILITY <input type="checkbox"/> 3 OR MORE PEOPLE HOSPITALIZED <input type="checkbox"/> 1 OR 2 PEOPLE HOSPITALIZED <input type="checkbox"/> LOSS OF CONSCIOUSNESS <input type="checkbox"/> FULL LOST WORKDAY(S) <input type="checkbox"/> RESTRICTED WORKDAY(S) <input type="checkbox"/> MEDICATION OR MEDICAL TREATMENT ADMINISTERED <input type="checkbox"/> INJURY OR ILLNESS <input type="checkbox"/> FIRST AID ONLY WAS ADMINISTERED	<input type="checkbox"/> SERIOUS DAMAGE TO AIRCRAFT OR SPACE HARDWARE <input type="checkbox"/> SERIOUS DAMAGE TO FLIGHT OR GROUND SUPPORT HARDWARE <input type="checkbox"/> UNEXPECTED DAMAGE DUE TO TEST FAILURE <input type="checkbox"/> DAMAGE ESTIMATE OVER \$1,000,000 <input type="checkbox"/> DAMAGE ESTIMATE BETWEEN \$250K AND \$1M <input type="checkbox"/> DAMAGE ESTIMATE BETWEEN \$25K AND \$250K <input type="checkbox"/> DAMAGE ESTIMATE BETWEEN \$1K AND \$25K <input type="checkbox"/> DAMAGE ESTIMATE UNDER \$1K <input type="checkbox"/> AFFECTED PRIMARY OBJECTIVE(S) OF MISSION <input type="checkbox"/> SIGNIFICANT PROGRAM IMPACT <input type="checkbox"/> HIGH VISIBILITY (internal or external to NASA)
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☐ CLOSE CALL

15. LEVEL OF POTENTIAL FOR THIS EVENT OR CLOSE CALL (Using reasonable judgment, check the boxes which you believe have a **HIGH** probability of occurring under similar conditions.)

<input type="checkbox"/> FATALITY <input type="checkbox"/> PERMANENT DISABILITY <input type="checkbox"/> 3 OR MORE PEOPLE HOSPITALIZED <input type="checkbox"/> FULL LOST WORKDAY(S)	<input type="checkbox"/> POTENTIAL DAMAGE ESTIMATE OVER \$250,000 <input type="checkbox"/> POTENTIAL DAMAGE ESTIMATE UNDER \$250,000 <input type="checkbox"/> SERIOUS DAMAGE TO AIRCRAFT OR SPACE HARDWARE <input type="checkbox"/> SERIOUS DAMAGE TO FLIGHT OR GROUND SUPPORT HARDWARE	<input type="checkbox"/> UNEXPECTED DAMAGE DUE TO TEST FAILURE <input type="checkbox"/> AFFECT PRIMARY OBJECTIVE(S) OF MISSION <input type="checkbox"/> SIGNIFICANT PROGRAM IMPACT <input type="checkbox"/> HIGH VISIBILITY (internal or external to NASA)
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PERSON INVOLVED IN INJURY OR ILLNESS

16. NAME (Last, First MI)		17. ORGANIZATION	18. CONTRACT NUMBER	19. JOB TITLE/OCCUPATION	
20. SUPERVISOR'S NAME (Full Name)		21. SUPERVISOR'S ORGANIZATION	22. SUPERVISOR'S MAIL CODE	23. SUPERVISOR'S PHONE	
24. AGE	25. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	26. SHIFT WORKED <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd	27. CONTINUOUS DUTY HOURS	28. YEARS OF EXPERIENCE <input type="checkbox"/> Under 1 <input type="checkbox"/> Under 5 <input type="checkbox"/> Under 10 <input type="checkbox"/> Over 10	
29. INJURY OR ILLNESS <input type="checkbox"/> INJURY <input type="checkbox"/> ILLNESS	30. FROM PRE-EXISTING <input type="checkbox"/> YES <input type="checkbox"/> NO	31. FATALITY? <input type="checkbox"/>	32. DATE OF DEATH	33. PERMANENT DISABILITY? <input type="checkbox"/>	34. # OF FULL LOST WORKDAYS
35. # OF RESTRICTED WORKDAYS					
36. INJURY TYPE(S) (e.g., Abrasion, Burn, Concussion, Laceration, etc.)			37. AFFECTED BODY PART(S) OR BODY SYSTEM(S)		
38. BRIEF MEDICAL DIAGNOSIS					
39. MEDICAL TREATMENT ADMINISTERED					
<input type="checkbox"/> TREATMENT OF INFECTION <input type="checkbox"/> APPLICATION OF ANTISEPTIC <input type="checkbox"/> 2ND OR 3RD DEGREE BURN(S) <input type="checkbox"/> CUT AWAY DEAD SKIN <input type="checkbox"/> POSITIVE X-RAY DIAGNOSIS		<input type="checkbox"/> APPLICATION OF SUTURES <input type="checkbox"/> USE OF BUTTERFLY ADHESIVE <input type="checkbox"/> REMOVAL OF FOREIGN OBJECT(S) <input type="checkbox"/> USE OF HEAT THERAPY <input type="checkbox"/> ADMISSION TO HOSPITAL FOR MORE THAN OBSERVATION		<input type="checkbox"/> REMOVAL OF OBJECT IN WOUND <input type="checkbox"/> USE OF PRESCRIPTION MEDICATION <input type="checkbox"/> HOT OR COLD SOAKING/COMPRESS THERAPY <input type="checkbox"/> USE OF WHIRLPOOL BATH THERAPY <input type="checkbox"/> FIRST AID ONLY	
40. OTHER MEDICAL TREATMENT ADMINISTERED					

EQUIPMENT/PROPERTY DAMAGED

41. CLASS OF EQUIPMENT/PROPERTY DAMAGED <input type="checkbox"/> FLIGHT HARDWARE <input type="checkbox"/> GROUND SUPPORT EQUIPMENT <input type="checkbox"/> FACILITY <input type="checkbox"/> PRESSURE VESSEL <input type="checkbox"/> MOTOR VEHICLE	<input type="checkbox"/> AIRCRAFT <input type="checkbox"/> OTHER	42. ESTIMATED COST OF ALL DAMAGED ITEMS <input type="checkbox"/> OVER \$1,000,000 <input type="checkbox"/> BETWEEN \$250K AND \$1M <input type="checkbox"/> BETWEEN \$25K AND \$250K <input type="checkbox"/> BETWEEN \$1K AND \$25K <input type="checkbox"/> UNDER \$1,000	43. # OF ITEMS DAMAGED _____
43. SPECIFIC ITEM(S) DAMAGED			

SUBMITTER

44. SUBMITTED BY (Full Name)	45. ORGANIZATION	46. MAIL CODE	47. PHONE	48. DATE	49. TIME
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NASA Mishap Report
Part B: Causes and Corrective Action

MASTER FILE NO.

CAUSES

50. WHAT WAS THE DIRECT CAUSE(S)

51. WHAT OBJECTS OR SUBSTANCES WERE INVOLVED

52. WHAT ACTIVITIES OR UNSAFE ACTS WERE IN PROGRESS

INITIAL CORRECTIVE ACTION

53. INITIAL ACTION TAKEN (Summarize all corrective action taken)

54. DATE INITIATED

55. DATE COMPLETED

56. PERSON TAKING ACTION (Full Name)

57. ORGANIZATION

58. MAIL CODE

59. PHONE

PLANNED CORRECTIVE ACTION

60. PROPOSED ACTION TO BE TAKEN (Summarize any future action to be taken.)

61. EST. START DATE

62. EST. COMPL.

63. PERSON TAKING ACTION (Full Name)

64. ORGANIZATION

65. MAIL CODE

66. PHONE

67. PROPOSED ACTION TO BE TAKEN (Summarize any future action to be taken.)

68. EST. START DATE

69. EST. COMPL.

70. PERSON TAKING ACTION (Full Name)

71. ORGANIZATION

72. MAIL CODE

73. PHONE

Instructions

Complete the initial incident report (unshaded portions) and submit to your local NASA Safety Office within 24 hours of the incident occurrence. Complete and submit the follow-up report (with shaded areas) within ten working days of the incident. Retain a copy for your own files.

Working With This Form

This electronic document is a form. It has fields where you can enter information. You can use the mouse or TAB key to move between fields. The TAB key moves to the next field and SHIFT-TAB moves backwards. Some fields control the types of data that you can enter.

You should fill in this form electronically and send it to your local NASA Safety Office by electronic mail.

DETAILS

1. DATE OF INCIDENT - Enter date of the incident in MM/DD/YYYY format. Example: 6/1/2001.
2. TIME OF INCIDENT - Enter time of the incident using 24-hour clock. Examples: 09:30 for 9:30 AM or 14:15 for 2:15 PM.
3. GENERAL LOCATION - Identify the building, area, or facility where the incident occurred.
4. EXACT LOCATION - Describe the exact location of the incident. Example: Third floor, far west corridor.
5. RESPONSIBLE ORGANIZATION - Enter complete name of organization that is reporting the incident.
6. CONTRACT NUMBER - When the organization is a contractor, enter the contract number.
7. ORGANIZATION FILE NUMBER - Assign file number using your organization's unique four-character code, the mishap number (sequential) using four digits, and the fiscal year using two digits. Example: EGB1-0001-89.
- 8 - 10. ORGANIZATION POINT OF CONTACT, MAIL CODE, PHONE - Identify the person to contact at the organization.
11. MISSION AFFECTED - Enter the name or number of the mission, program, or project affected by the mishap. Examples: STS-32; Delta 181.
12. PROGRAM IMPACT - Describe the effect on the mission, program, or project in terms of delay or significant cost adjustment. Example: Two-week launch delay.
13. INCIDENT DESCRIPTION - Describe the event including information about the extent of damage and/or injury, conditions that led to the mishap, and cause if known at this time. Specify location of facility where medical treatment was provided. DO NOT include names of persons.

IMPACT SUMMARY

14. ACTUAL OUTCOMES - Mark every checkbox that represents current facts about the incident.
15. LEVEL OF POTENTIAL - Mark every checkbox that represents likely outcomes for the incident.

PERSONNEL INVOLVED IN INJURY OR ILLNESS

(If more than one person was injured, then attach a NASA Mishap Report (NF 1627) with only this section completed for each additional person.)

16. NAME - Self-explanatory.
17. ORGANIZATION - Identify the organization of the person involved.
18. CONTRACT NUMBER - When the organization is a contractor, enter the contract number.
19. JOB TITLE/OCCUPATION - Describe the job position of the person involved.
Example: Technician
- 20-23. SUPERVISOR'S NAME, ORGANIZATION, MAIL CODE, & PHONE - Provide identifying information about the supervisor of the person involved.
24. AGE - (of the person involved) Self-explanatory.
25. SEX - Check as appropriate.
26. SHIFT WORKED - Check as appropriate.
27. CONTINUOUS DUTY HOURS - Self-explanatory.
28. YEARS OF EXPERIENCE - Check as appropriate.
29. INJURY OR ILLNESS - Check as appropriate.
30. FROM PRE-EXISTING - Check as appropriate.
31. FATALITY? -
32. DATE OF DEATH -
33. PERMANENT DISABILITY? -
34. # OF FULL LOST WORKDAYS -
35. # OF RESTRICTED WORKDAYS -
36. INJURY TYPE(S) - Choose one or more items from the list. (See instructions below.)

37. AFFECTED BODY PART(S) or BODY SYSTEM(S) - Choose one or more items from the list. (See instructions below.)
38. BRIEF MEDICAL DIAGNOSIS -
39. MEDICAL TREATMENT ADMINISTERED - Mark every checkbox that represents treatment administered to the person involved. Mark the checkbox for "First Aid Only" if only First Aid treatment was administered to the individual.
40. MEDICAL TREATMENT ADMINISTERED - Describe any treatment not included in box #39.

EQUIPMENT/PROPERTY DAMAGE

41. CLASS OF EQUIPMENT/PROPERTY DAMAGED - Mark every checkbox that represents the type of damaged.
42. ESTIMATED COST OF ALL DAMAGED ITEMS - Mark one checkbox that represents the initially estimated cost of the damage. Provide Final Cost in follow-up report.
43. # OF ITEMS DAMAGED -
43. SPECIFIC ITEM(S) DAMAGED - Identify or describe the damaged items from box #41.
Example: If the class indicated in box #41 is Flight Hardware, then the specific item could be "Orbiter/Avionics."

SUBMITTER

- 44-47. SUBMITTED BY, ORGANIZATION, MAIL CODE, & PHONE - Provide identifying information about the person filling in this form.
- 48-49. DATE & TIME - Enter the date and time when the form is filled in.

CAUSES

50. DIRECT CAUSE(S) - Choose one or more items from the list. (See instructions below.)
51. OBJECTS OR SUBSTANCES INVOLVED - Choose one or more items from the list. (See instructions below.)
52. ACTIVITIES OR UNSAFE ACTS IN PROGRESS - Choose one or more items from the list. (See instructions below.)

INITIAL CORRECTIVE ACTION

53. INITIAL ACTION TAKEN -
54. DATE INITIATED -
55. DATE COMPLETED -
- 56-59. PERSON TAKING ACTION, ORGANIZATION, MAIL CODE, & PHONE - Provide identifying information about the person taking the initial corrective action.

PLANNED CORRECTIVE ACTION

60. PLANNED ACTION TO BE TAKEN -
61. ESTIMATED START DATE -
62. ESTIMATED COMPLETION -
- 63-66. PERSON TAKING ACTION, ORGANIZATION, MAIL CODE, & PHONE - Provide identifying information about the person taking the planned corrective action.
67. PLANNED ACTION TO BE TAKEN -
68. ESTIMATED START DATE -
69. ESTIMATED COMPLETION -
- 70-73. PERSON TAKING ACTION, ORGANIZATION, MAIL CODE, & PHONE - Provide identifying information about the person taking the planned corrective action.

Choosing items from a list

The list appears when you move the insertion point to this field. If the field already has data, then clicking with the mouse might not display the list again. In this case, click in an earlier field and use the TAB key to move forward and display the list.

To choose an item from the list first highlight the item you want. You can use the arrow keys or the mouse to highlight the proper item. Then either press the ENTER key, click the Ok button, or double click the item.

The list of items you have chosen is displayed at the top of the window. You can add many items to the list. To remove any item, you must edit the list with the DELETE or BACKSPACE keys. You can edit the list in the list window or you can edit the field on the form.